STATE OF MAINE

BOARD OF LICENSURE OF PODIATRIC MEDICINE

APPLICATION FOR LICENSURE

- Residency

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
HEARING IMPAIRED (888) 577-6690
Email: jennifer.l.mooney@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine

Revised: 01/2006

APPLICATION GUIDE

The application, along with all supporting documents and a check made payable to "Treasurer, State of Maine", must be submitted to the Board at least 60 days prior to the Board meeting at which you wish to have your application reviewed. Following an evaluation of your credentials, you will receive notice of the outcome of the evaluation. Before licensure may be granted, applicants must present themselves for and successfully pass an oral examination at a regular meeting of the Board.

The Board has adopted the National Board of Podiatric Medical Examiners Part III examination as its standard examination for licensure qualification. The examination will be offered in Maine in June and December of each year.

RESIDENCY APPLICATION

- ☐ A completed application form;
- ☐ Fees: All Checks/Money Orders should be made payable to the “Treasurer, State of Maine”. If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;
    - **$200.00** Application Fee
    - **$600.00** License Fee
    - **$15.00** Criminal History Check Fee
- ☐ Notarized copy of applicant’s CPR certification;
- ☐ Notarized copy of Podiatric degree;
- ☐ Official documentation of passing scores on Parts I and II of the National Boards; and
- ☐ Official documentation of Pre-Podiatric education.

If you need any additional information or have any questions please contact Jennifer Mooney at (207) 624-8626 or email at jennifer.l.mooney@maine.gov

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JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

Office Use Only
License # _____
Cash # _____
Check # _____
4400 1422 $600 RES
4400 1446 $200
4400 2619 $15

APPLICATION FOR LICENSURE AS A MAINE LICENSED RESIDENCY PODIATRIST

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

☐ **Written Examination - please check here if requesting to sit for Part III National Boards**

Name_____

Any other names used_____

Address _____

_____

Phone number (work) _____ (home) _____

Social Security number _____ Sex _____

Birthplace _____ Birth date_____

COLLEGE EDUCATION

Name of Institution _____

Location _____

Dates attended: from _____ to _____

Degree: _____ Date of degree: _____

PODIATRY EDUCATION

Name of Institution _____

Location _____

Dates attended: from _____ to _____

Degree: _____Date of degree: _____

PERSONAL DATA

If any of the following questions are answered yes, please provide details on a separate sheet and attach to application.

1. Have you ever been called before any state board for any violation of the podiatric practice act of unethical behavior? _____

2. Have you ever had a license to practice podiatry revoked or suspended?

_____

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

3. Have you ever been convicted of a crime other than a minor traffic violation?

_____

If yes, please describe in detail the date(s), crime(s) and submit a copy of the court judgment(s) as well as a letter from you explaining the circumstances surrounding your conviction.

4. Have you ever received psychiatric treatment or treatment for mental illness?

_____

5. Have you ever been addicted to or treated for addiction to narcotic drugs or alcohol?

_____

6. Have you ever been convicted of a violation of any narcotic drug law?

_____

7. Have you ever been denied a license or the privilege of taking the examination for licensure by any state podiatric board? _____

8. Have you ever been denied a DEA registration number or have you been issued a restricted DEA registration? _____

9. Have you ever had any malpractice suits filed against you? _____

10. Have you ever used any other names? _____

PLEASE PLACE RECENT
PHOTOGRAPH HERE

PROFESSIONAL EDUCATION AND EXPERIENCE

Please list all professional education & experience including college, podiatric school, residencies and practice. Include all periods of time from the date of graduation from podiatric school to present, whether or not engaged in activities related to podiatry.

- **Notarized copy of certificate(s) must accompany application.**

DATES FROM - TO	NAME & ADDRESS OF INSTITUTION, PLACE OF PRACTICE OR OTHER	DEGREE, CERT., OR NATURE OF EXPERIENCE

HOSPITAL AFFILIATIONS

List names & addresses of all U.S. or Canadian hospitals/institutions where you are or were a member of the staff (if not included in the above listing)

DATES FROM - TO	NAME AND COMPLETE ADDRESS OF HOSPITAL OR INSTITUTION

AFFIDAVIT OF APPLICANT

I have read and completed this application and attest that all information is true to the best of my knowledge. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice podiatry in the state of Maine.

I hereby authorize all hospitals, podiatric institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies to release to this licensing board, for it's evaluation, any information, files or records required by the board.

Signature of applicant _____

Subscribed and sworn to before me this _____day of_____, 20_____

Notary public for _____

My commission expires _____

PLEASE PLACE
NOTARY SEAL HERE

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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)_____-_____***	

Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____Date: _____/_____/_____

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DISCIPLINARY REPORTS

State licensing boards may require a Federation disciplinary data bank report at the time an application for licensure is presented. The data bank lists completed public record actions taken by state boards or reported by the DHHS Inspector General. If no adverse actions are on file, a form sent in by the candidate will be validated accordingly and returned to the state board.

SEND THIS FORM AND PAYMENT IN CERTIFIED FUNDS
(TELLER'S CHECK, BANK/POSTAL MONEY ORDER)
IN THE AMOUNT OF $40 TO:

Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, Florida 33437

Name: _____

Address (where you can be reached): _____

City, State, Zip: _____

Telephone (where you can be reached): _____

Date of Birth: _____

Social Security Number: _____

School and Year of Graduation: _____

STATE BOARD TO RECEIVE THIS REPORT:

Maine Board of Licensure of Podiatric Medicine
35 State House Station
Augusta, ME 04333

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CERTIFICATE OF PODIATRIC EDUCATION

I am applying to practice podiatry in the state of Maine. The Maine board requires verification of my podiatric education. This is your authority to release any information in your files directly to the Maine board at the above address.

THIS SECTION TO BE COMPLETED BY THE APPLICANT.

Applicant's name: _____

Applicant's address: _____

Dates of attendance: from _____to_____

THIS SECTION MUST BE COMPLETED BY THE DEAN, SECRETARY OR REGISTRAR OF THE PODIATRIC SCHOOL.

I hereby certify that the above named applicant has received the degree of doctor of podiatric medicine.

Name of podiatric school_____

Address of school_____

Dates of attendance: from _____ to_____

Degree conferred: _____ date conferred: _____

Name & title of school official: _____

Official's signature_____ dated: _____

PLEASE PLACE SCHOOL SEAL HERE

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REQUEST FOR PART I & II EXAMINATION CERTIFIED SCORE REPORT

INSTRUCTIONS: Applicants for licensure who:

(1) Have already taken the Part I & Part II in another state; **AND**

(2) Whose score has been reported to that state's licensing board may (by completing this form **AND** including money order or teller certified funds in the amount of $35 payable to FPMB) request that the Federation certify that score to another state board. The $35 fee applies to each score report to every additional (second, third, etc.) state board.

SEND THIS FORM AND PAYMENT IN CERTIFIED FUNDS
(TELLER'S CHECK, BANK/POSTAL MONEY ORDER) TO:

Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, Florida 33437

Name: _____

Address (where you can be reached): _____

City, State, Zip: _____

Telephone (where you can be reached): _____

State in which you took the PMLexis: _____

Date (month and year) on which you took the PMLexis: _____

School and Year of Graduation: _____

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VERIFICATION OF LICENSURE FORM

****

I am applying for licensure to practice podiatry in the state of Maine. The Maine board of licensure of podiatric medicine requests verification of licensure from the states where I hold or have held licensure. This is your authority to release any information in your files, favorable or otherwise, directly to the Maine board. Please return completed form directly to the Maine board at the above address.

****

THIS SECTION TO BE COMPLETED BY THE APPLICANT.

Applicant's name: _____

Applicant's address: _____

Dates of attendance: from _____to_____

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE PODIATRY BOARD

Licensee name and address: _____

_____

Dates of issue: _____ expiration date: _____

License issued by: examination _____ endorsement_____

If licensed by examination, please list subjects examined on and score for each subject:
_____

_____

Is applicant considered a podiatrist in good standing in your state? _____
If no, please attach an explanation.

Have there been any actions taken against the licensee by your board? _____
If yes, please attach an explanation.

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The _____state board hereby agrees to extend the privilege of licensure without examination to applicants licensed by examination in the state of Maine who meet the licensing requirements of this state.

Name of state board: _____

Name of official completing form: _____

Official's title: _____

Official's signature: _____date:_____

PLEASE PLACE
BOARD SEAL HERE